

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

16752

CERTIFICATE OF DEATH

16747

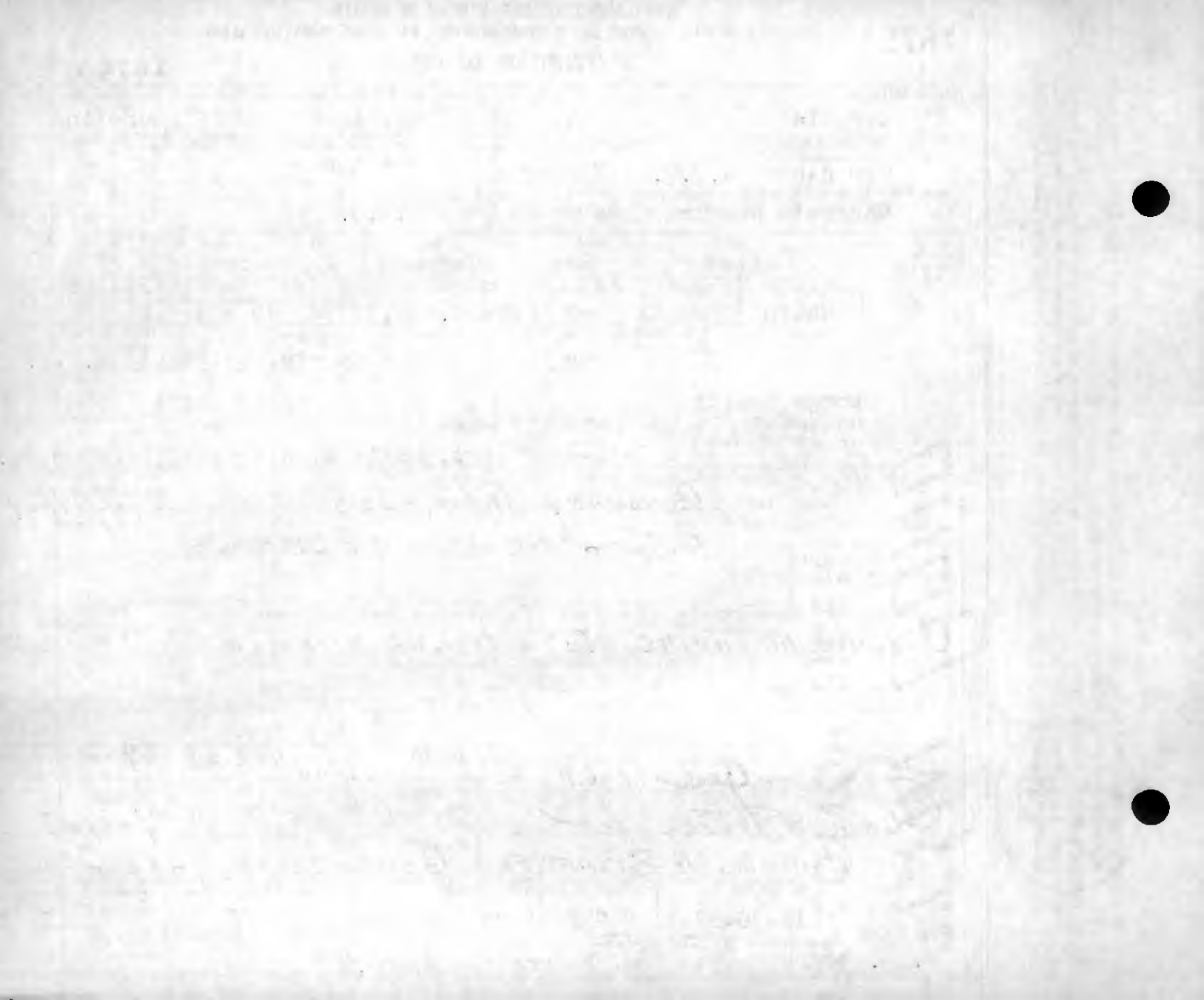
1. PLACE OF DEATH a. COUNTY CAROLINE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. MARY LAND b. COUNTY CAROLINE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RODGELY		c. LENGTH OF STAY IN 1b LDTE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RODGELY		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle DENNIS Last BENE BRENK				4. DATE OF DEATH Month DEC Day 6 Year 1967			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR 17, 1889	9. AGE (In years, month, day) 78 yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES MAN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARY LAND		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME WILLIAM J. BENE BRENK				14. MOTHER'S MAIDEN NAME NORA LANE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Address MRS. W.M. BENE BRENK, RODGELY			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO decompensation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/30/67 , 19 67 , to 11/20 , 19 67 , that (I) (we) last saw the deceased alive on 11/20/67 , and that death occurred at 10:00 M, from causes and on the date stated above.							
22a. SIGNATURE Phly D. Dwyer				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/5/67	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC 9, 1967		23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT		23d. LOCATION (City or Town) (County) (State) HILLSBORO MD.	
24. FUNERAL DIRECTOR D. VERGEL MOORE				ADDRESS DENTON MD.		25a. RECD BY REGISTRAR DEC 12 1967	
				25b. REGISTRAR'S SIGNATURE Charles J. Jones			

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Caroline MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro R.F.D.			c. LENGTH OF STAY IN lb 7 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cherry's Nursing Home					d. STREET ADDRESS R.F.D.			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alice Middle Mae Last Johnson					4. DATE OF DEATH Month December Day 27 Year 1967				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 20, 1879		9. AGE (In years last birthday) 88 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Sussex County, Delaware			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George Truitt					14. MOTHER'S MAIDEN NAME Annie Betts				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 213-22-7323		17. INFORMANT Address Mrs. Marie S. Hilprect, Preston, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO (b) ARTERIO SCLEROTIC C.V. DISEASE DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH 12/27/67	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CHRONIC ARTHRITIS; NUTRITIONAL ANEMIA								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from JAN 10, 1967 , to DEC 27, 1967 , that (I) (we) last saw the deceased alive on OCT 27, 1967 , and that death occurred at 10 A.M. , from causes and on the date stated above.									
22a. SIGNATURE Charles H. Stinesifer					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/28/67		
22c. PHYSICIAN'S NAME (Type) CHARLES H. STINESIFER					22d. ADDRESS GREENSBORO, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-30-67		23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery		23d. LOCATION (City or town) (County) (State) Seaford, Sussex Del.			
24. FUNERAL DIRECTOR Margaret H. Frampton J. J. Frampton and Son, Federalburg, Md.					25a. REC'D BY REGISTRAR JAN 2 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



CERTIFICATE OF DEATH

16754

16740

1. PLACE OF DEATH a. COUNTY CAROLINE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if instituting; Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RI DGE LY		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 051	
3. NAME OF DECEASED (Type or print) First ANNIE Middle TODD Last SAMES		4. DATE OF DEATH Month DEC Day 23 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 26, 1875
9. AGE (In years last birthday) 92 yrs.		10. IF UNDER 1 YEAR: Months 9 Days 23 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME JAMES MASON		14. MOTHER'S MAIDEN NAME MATILDA JOHNSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. PAGE JONES, RIDGELY MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Virulent Viral Enterocolitis DUE TO (b) 571.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic C.V. Disease, Disabling old fracture of the hip			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec. 16 , 19 67 , to Dec 23 , 19 67 , that (I) (we) last saw the deceased alive on Dec. 23 , 19 67 , and that death occurred at 12 M, from causes and on the date stated above.			
22a. SIGNATURE Charles H. Stonesifer		22b. DATE SIGNED 12/26/67	
22c. PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.		22d. ADDRESS Greensboro, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF Dec. 26, 1967	23c. NAME OF CEMETERY OR CREMATORY RIDGELY	23d. LOCATION (City or Town) (County) (State) RIDGELY CAR. MD.
24. FUNERAL DIRECTOR CHARLES V. MOORE		25a. REC'D BY REGISTRAR DEC 29 1967	
ADDRESS JENTON RD.		25b. REGISTRAR'S SIGNATURE James Judge	

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Henderson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Henderson	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None		d. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) Ida Schuyler		4. DATE OF DEATH Month 12- Day 26 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-8-1873
9. AGE (In years last birthday) 94 yrs.		10. IF UNDER 1 YEAR Months 05 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HouseKeeper		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Schuyler		14. MOTHER'S MAIDEN NAME Matelda Hughes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Edward Schuyler Henderson, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4221 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO (b) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Malnutrition and Nutritional Anemia			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 1, 1967 , to Dec. 26, 1967 (that (I) (we) last saw the deceased alive on Dec. 26, 1967 , and that death occurred at 11 M, from causes and on the date stated above.			
22a. SIGNATURE Charles H. Stonecipher, M.D.		22b. DATE SIGNED Dec. 28 '67	
22c. PHYSICIAN'S NAME (Type) Charles H. Stonecipher, M.D.		22d. ADDRESS Greensboro, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-29-67	
23c. NAME OF CEMETERY OR CREMATORY Greensboro		23d. LOCATION (City or Town) (County) (State) Greensboro, Maryland	
24. FUNERAL DIRECTOR J. E. Boulaie, Greensboro, Md.		25a. REC'D BY REGISTRAR DATE JAN 4 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1945

1945

Director

Assistant

Assistant

Assistant

Assistant

Assistant

None

None

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BALTIMORE, 18

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16756

16751

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston, Md. RFD.				c. LENGTH OF STAY IN 1b 37 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) rural				d. STREET ADDRESS none			
3. NAME OF DECEASED (Type or print) First Middle Last Thomas M. Wood				4. DATE OF DEATH Month Day Year Dec. 10, 1967 19			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 12, 1917	
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY bldg. supply co.		11. BIRTHPLACE (State or foreign country) Boston, Mass.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Albert T. Wood				14. MOTHER'S MAIDEN NAME Cora Fuller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Mary Jane Wood				Address Preston, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident Probably Hemorrhage minutes DUE TO (b) Hypertensive arteriosclerotic Hardening of Arteries Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Generalized arteriosclerosis severe for age 15 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?full mental capacity mental age of about 12yrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>[Signature]</i> EXAMINER'S NAME (Type) Harold B. Plummer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Caroline Maryland			
DATE SIGNED 12/12/67							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12/13/67		22c. NAME OF CEMETERY OR CREMATORY Bloomery Cem.		22d. LOCATION (City, town, or county) (State) Federalsburg, Md. RFD.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i> ADDRESS Federalsburg, Md.				24a. REC'D BY REGISTRAR DEC 15 1967		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

THIS IS TO CERTIFY THAT the within and foregoing is a true and correct copy of the original as the same appears in the files of the Medical Examiner's Office.

RECEIVED
MEDICAL EXAMINER'S CERTIFICATE